University of Massachusetts
325 Whitmore Administration Building
181 President's Drive
Amherst, MA 01003-9313

Division of Human Resources
Workers' Compensation
Telephone: 413.545.6114
Facsimile: 413.545.0483

NOTICE OF INJURY REPORT

This form is intended for internal use for all Human Resources Division/Workers' Compensation Unit user agencies and must be completed in its entirety. All Notice of Injury Reports must be electronically filed via eServices within 48 hours of an Industrial Accident. Please print clearly.

EMPLOYEE

Soc. Sec. #: _____ Date of Injury: _____ mm/dd/yyyy

Department: _____

Name: _____
(First) (Middle) (Last)

Sex: ☐ Male ☐ Female Employee ID#: _____ Record #: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Date of Birth: _____ Marital Status: ☐ S ☐ M

EMPLOYER

State Hire Date: _____ Department Hire Date: _____

Status: ☐ Full-Time Employee ☐ Part-Time Employee Work Hours/Wk: _____

Shift ☐ 1st ☐ 2nd ☐ 3rd Number of scheduled days off per week: _____

Occupation: (Official Position Title) _____

Functional Title: _____

Payroll Funding Source: ☐ State Payroll ☐ Trust Funded ☐ Federal Funded

INJURY INFO

Injury Time: _____ am / pm Date Reported: _____

Time work began on day of event: _____ am / pm

Event occurred: ☐ Before ☐ During ☐ After Work Shift 3rd Party Claim: ☐ Yes ☐ No

Describe how injury/illness occurred:

What was employee doing (eg, pouring cleaning solution into a bucket):

_____

How did the injury/illness occur (eg, cleaning solution splashed):

_____

What was the source of the injury/illness (eg, cleaning solution):

_____

INJURY INFORMATION

Nature of Injury/Illness (eg, chemical burn to right eye):

_____

Body part(s) affected (include right, left or both):

_____

Injury Detail: Insert body part(s) and injury below from lists on pages 5 and 6.

Select Body Part(s): _____ Select Injury: _____

Select One or More Injury Categories:

- ☐ Fall
- ☐ Assault
- ☐ Equipment
- ☐ Burn
- ☐ Needlestick/Bloodborne Pathogen Exposure
- ☐ Lifting
- ☐ Exposure to Harmful Substances
- ☐ Moving/Walking
- ☐ Cut
- ☐ MVA (Motor Vehicle Accident)
- ☐ Repetitive Use
- ☐ Stress/Heart Attack
- ☐ Restraint
- ☐ Other _____

Severity of Injury or Illness:

- ☐ (1) Minor injury; no likely lost time; no likely medical bills
- ☐ (2) Small injury; no likely lost time; possible medical bills
- ☐ (3) Moderate injury; possible lost time; probable medical bills
- ☐ (4) Significant injury; probably 0 – 5 days of lost time and medical bills
- ☐ (5) Severe injury; probably 5 plus days lost time and medical bills

Where the Injury Occurred:

Building: _____

Injury Location: _____

Example: stairwell, south walkway, office

INVESTIGATION

Was the incident the result of a violent act? ☐ Yes ☐ No

Was the claimant engaging in usual job activities? ☐ Yes ☐ No

If no, explain: _____

_____

Injury reported to: _____

(Name, Title)

Did the Injured / Ill worker:

a. Lose consciousness? ☐ Yes ☐ No

b. Require medical treatment more than first aid? ☐ Yes ☐ No

c. Have an injury from a contaminated needlestick or other sharp device? ☐ Yes ☐ No

d. Have a significant work-related injury/illness diagnosed by a health care professional? ☐ Yes ☐ No

e. Require transfer to another job or modified duty? ☐ Yes ☐ No

INTERNAL INVESTIGATION

If employee died as a result of injury/illness, what was the date of death? _____/_____/_____

Supervisor: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

_____

Manager: Are you satisfied that the injury occurred as stated? ☐ Yes ☐ No

If no, explain: _____

_____

Was the incident witnessed? ☐ Yes ☐ No

If yes, provide the names of witnesses and ask that each prepare a witness statement.

Witness: Name_____Title_____Phone_____

Name_____Title_____Phone_____

Did employee seek medical attention? ☐ Yes ☐ No

If yes, where?

a. Facility: _____

b. Address: _____
(street, town, zip code)

Did the employee seek medical attention away from the worksite?	☐ Yes	☐ No	
Was the employee treated in an emergency room?	☐ Yes	☐ No	
Was the employee hospitalized overnight as an in-patient?	☐ Yes	☐ No	
Is employee a disabled veteran or has any other known disability?	☐ Yes	☐ No	☐ Unknown
Do you feel the employee would benefit from any referral to Rehabilitation?	☐ Yes	☐ No	☐ Unknown
Do you feel claim warrants further investigation?	☐ Yes	☐ No	

Please attach if possible any information you feel would be useful to HRD/WC Section (i.e. claimant's job description, etc.) in managing this claim.

_____ _____
Supervisor Signature Please print name

Title: _____ Date_____

University of Massachusetts
325 Whitmore Administration Building
181 President's Drive
Amherst, MA 01003-9313

Division of Human Resources
Workers' Compensation
Telephone: 413.545.6114
Facsimile: 413.545.0483

WORKERS' COMPENSATION
AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Employee's Name: _____

Social Security Number _____

Address: _____

_____

_____

Telephone Number: _____

Employing Agency and Location: UMA4
___UMASS Amherst____

Date of injury: _____
mm/dd/yyyy

I am filing a claim for workers' compensation benefits and hereby authorize any hospital or other medical provider to release to the Human Resources Division (HRD), Workers' Compensation Section, **any and all information relative to my claim for benefits, including, but not limited to, psychiatric records, records pertaining to HIV (AIDS) or other records especially those protected by law**. I understand that HRD may share this information with my employer, medical and or vocation rehabilitation consultants, utilization review consultants, physicians and other medical care providers and other state agencies involved in the workers' compensation process and I hereby authorize such release to the other persons and entities described.

Signature: _____ Date: _____

Body Parts List

Head	Hip/Buttocks/Groin (Buttocks)	**Upper Extremities**
Brain	Hip/Buttocks/Groin (Groin)	Arm(s), unspecified (Left)
Ear(s), unspecified	Hip/Buttocks/Groin (Hips)	Arm(s), unspecified (Right)
Ear(s), external	Shoulder(s) (Left)	Arm(s), unspecified (Both)
Ear(s), internal	Shoulder(s) (Right)	Arm(s), unspecified (Armpit)
Eye(s) (Left)	Shoulder(s) (Both)	Arm(s), upper (Left)
Eye(s) (Right)	Trunk, Multiple	Arm(s), upper (Right)
Eye(s) (Both)	**Lower Extremities**	Arm(s), upper (Both)
Face, unspecified	Leg(s), unspecified (Left)	Elbow(s) (Left)
Jaw, Chin	Leg(s), unspecified (Right)	Elbow(s) (Right)
Mouth & Throat (Lips)	Leg(s), unspecified (Both)	Elbow(s) (Both)
Mouth & Throat (Multiple)	Knee(s) (Left)	Arm(s), lower (forearm) (Left)
Mouth & Throat (Tongue)	Knee(s) (Right)	Arm(s), lower (forearm) (Right)
Mouth & Throat (Tooth/teeth)	Knee(s) (Both)	Arm(s), lower (forearm) (Both)
Mouth & Throat (Unspecified)	Leg(s), lower (e.g. calf, shin) (Left)	Arm(s), multiple (Left)
Mouth & Throat (Internal (e.g. vocal cords, larynx))	Leg(s), lower (e.g. calf, shin) (Right)	Arm(s), multiple (Right)
Nose	Leg(s), lower (e.g. calf, shin) (Both)	Arm(s), multiple (Both)
Face, multiple	Leg(s), multiple (Left)	Wrist(s) (Left)
Face (Cheeks)	Leg(s), multiple (Right)	Wrist(s) (Right)
Face (Forehead)	Leg(s), multiple (Both)	Wrist(s) (Both)
Scalp	Leg(s), upper (e.g. thigh, hamstring) (Left)	Hand(s), not wrist/fingers (Left)
Skull	Leg(s), upper (e.g. thigh, hamstring) (Right)	Hand(s), not wrist/fingers (Right)
Head, Multiple	Leg(s), upper (e.g. thigh, hamstring) (Both)	Hand(s), not wrist/fingers (Both)
Head	Ankle (Left)	Finger(s)
Neck	Ankle (Right)	Upper Extremities, multiple (Left)
Neck & cervical vertebrae	Ankle (Both)	Upper Extremities, multiple (Right)
Trunk	Foot or Feet, except ankle/toe (Left)	Upper Extremities, multiple (Both)
Trunk, UNS	Foot or Feet, except ankle/toe (Right)	**Other**
Abdomen, internal organs/hernia	Foot or Feet, except ankle/toe (Both)	Other (Body system)
Back	Toe(s)	Other (Multiple body parts)
Chest/Breastbone (Internal organs)	Lower Extremities, multiple (Left)	Non-Classifiable
Chest/Breastbone (Ribs, breastbone)	Lower Extremities, multiple (Right)	
	Lower Extremities, multiple (Both)	

List of Injury Types

Acute Injuries	**Mental disorders**
Amputation, enucleation	Mental disorders (Anxiety attacks)
Asphyxia, suffocation	Mental disorders (Other mental disorder or syndrome)
Burn, heat	Mental disorders (Stress)
Burn, chemical	**Other Work-related diseases/disorders**
Concussion	Other occupational disease
Contusion, crushing, bruise	Diseases of central nervous system
Cut, laceration, puncture (Except needlestick injury)	Diseases of peripheral nerves and ganglia
Cut, laceration, puncture (Needlestick/sharp injury)	Disease of the blood and blood forming organs
Cut, laceration, puncture (Splinter, chip (foreign body))	Disease of the gastro-intestinal tract
Dislocation	Carpal tunnel syndrome
Fracture	**Poisoning and toxic effects**
Effects of exposure to low temperature	Other poisoning due to toxic materials
Effects of environmental heat	Effects of lead
Hernia, rupture	**Respiratory conditions**
Effects of radiation	Other respatory condition
Scratches, abrasion	Upper respiratory condition (e.g. allergic rhinitis)
Sprains, strains	Asthma
Multiple injuries	Asbestosis
Effects of atmospheric pressure	Silicosis
Bite/Burn/Other Injury (Bite, animal)	Influenza/Pneumonia (Influenza)
Bite/Burn/Other Injury (Bite, human)	Influenza/Pneumonia (Pneumonia)
Bite/Burn/Other Injury (Bite, insect)	**Skin conditions**
Bite/Burn/Other Injury (Burn, other)	Dermatitis
Bite/Burn/Other Injury (Other injury)	Infections of the skin
Electric shock/electrocution	Other skin conditions
Heart/Circulatory System Conditions	**Tumor, cancer**
Heart/Circulatory System (Heart condition/attack)	Tumor, unspecified
Heart/Circulatory System (High blood pressure)	Malignant Tumor
Heart/Circulatory System (Stroke or other circulatory condition)	Benign Tumor
Hearing and eye disorders	**Symptoms, ill defined conditions**
Hearing loss or impairment	Symptoms, ill defined conditions (Back pain, hurt back)
Conjunctivitis	Symptoms, ill defined conditions (Chest pains)
Other diseases of the eye	Symptoms, ill defined conditions (Dizziness)
Infectious or parasitic diseases	Symptoms, ill defined conditions (Headaches, migraine)
Tetanus	Symptoms, ill defined conditions (Nausea, vomiting)
Tuberculosis	Symptoms, ill defined conditions (Pain/Soreness, except back or chest)
Infectious/Parasasitic Diseases (Lyme disease)	Symptoms, ill defined conditions (Sick building syndrome)
Infectious/Parasasitic Diseases (Other infectious or parasitic diseases)	Symptoms, ill defined conditions (Other symptoms and ill defined conditions)
Hepatitis - viral	**Other**
Inflammation of the joints or tendons	No injury or illness
Joint Inflammation, etc. (Arthritis)	Damage to prosthetic devices
Joint Inflammation, etc. (Bursitis)	Non-classifiable (Exposure to saliva/body fluids)
Joint Inflammation, etc. (Other Inflammation of the joints)	Non-classifiable (Non-classifiable)
Joint Inflammation, etc. (Sciatica)	Complications peculiar to medical care
Joint Inflammation, etc. (Tendonitis)	